Sample Patient Contract
For
Using Opioid Pain Medication in Chronic Pain

This is an agreement between _____and _____
(the Patient) (Prescriber's name)
concerning the Use of opioid analgesics (narcotic pain-killers) for the treatment of chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and I have been informed of the risks and side effects involved with taking them.

2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweating, and chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable but not a life-threatening condition.

   I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioid, and withdrawal can be life-threatening for a baby.

3. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know that I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.

4. If the medication caused drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in danger.

5. I understand it is my responsibility to inform the prescriber of any and all side effects that I have from this medication.

6. I agree to take this medication as prescribed, and not to change the amount or frequency of the medication without discussing it with the prescriber. Running out early, needing early refills, escalating doses without permission and losing prescriptions may be signs of misuse of the medication, and may be reasons for the prescriber to discontinue prescribing to me.

7. I agree that the opioid will be prescribed by only one prescriber, and I agree to fill my prescriptions at the one pharmacy. I agree not to take any pain medication or mind altering medication prescribed by any other prescriber without first discussing it with the above named prescriber. I give permission for the prescriber to verify that I am not seeing other prescribers for opioid medication or going to other pharmacies.

8. I agree to keep my medication in a safe and secure place. Lost, stolen or damaged medication will not be replaced.

9. I agree not to sell, lend or in any way give my medication to any other person.

10. I agree not to drink alcohol or take mood altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my prescriber requests, and give my permission for it to be tested for alcohol and drugs.

11. I agree that I will attend all required follow-up visits with the prescriber to monitor this medication, and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my prescriber.

12. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addition. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions and understand the agreement. If I violate the agreement, I know that the prescriber may discontinue this form of treatment.

(Patient signature)

Prescriber Signature

Date

Addendum:
Sample Statement that could be in this agreement or included in chart at each visit:
I understand that the medication is prescribed as follows:
Type of medication _____
Number of fills and frequency_____